



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RENAISSANCE HOSPITAL HOUSTON
C/O BURTON & HYDE PLLC
PO BOX 684749
AUSTIN TX 78768-4749

Carrier's Austin Representative Box
#19

MFDR Date Received
FEBRUARY 8, 2008

Respondent Name

AMERICAN HOME ASSURANCE CO

MFDR Tracking Number

M4-08-3643-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated February 4, 2008: "This bill should have been audited and reimbursed per the Stop-Loss reimbursement factor and methodology per the criteria as defined in TDI-DWC rule 134.401(c)(6)(A)...Per the stop-loss method the carrier should have reimbursed the provider \$56,322.83..."

Requestor's Supplemental Position Summary Dated October 2, 2011: "1. The Audited charges of \$75,097.10 for [Claimant's] hospital inpatient admission exceeds the \$40,000 stop-loss threshold. 2. The services rendered to [Claimant] were unusually costly and extensive...because:

- **[Claimant] underwent multiple surgeries.** [Claimant's] hospital stay involved multiple surgical procedures. Dr. Younan Nowzaradan conducted a laparotomy, retroperitoneal dissection, mobilization of abdominal aorta and inferior vena cava with division of lumbar communication vessels and exposure of L4-L5 vertebral body and intervertebral disc space; laparotomy, retroperitoneal dissection, mobilization of abdominal aorta and inferior vena cava with division of lumbar communicating vessels and exposure of L5-S1 vertebral body and intervertebral disc space; c-arm fluoroscopy; and he assisted Dr. James Key in an anterior lumbar surgery to fuse L4-L5 and L5-S1. Dr. James Key conducted an anterior discectomy of L4-L5 and L5-S1; additionally he inserted a graft prosthesis. After these spinal procedures, Dr. James Key conducted a trial stimulator for [Claimants'] failed lower back syndrome with bilateral radiculopathy.
- **[Claimant] suffered complications.** The placement of the electrode on [Claimants'] right side backed out and required replacement. When a trial of the electrodes was conducted, while [Claimant] was in recovery, she experience rib pain. [Claimant] also had a dural leak that caused her pain and a headache. Post surgery [Claimant] experienced nausea and pain from the procedure.
- **The costs were front-loaded.** The cost associated with the hospital's services in this case are front loaded-i.e. the injured employee underwent complicated surgical procedures requiring an investment in skilled professionals and advanced facilities and medical equipment... For these reasons, the Medical Fee Dispute Officer should find that the second-prong of the two part test is satisfied and order additional reimbursement be paid by the carrier according to the stop-loss calculation methodology."

Amount in Dispute: \$44,187.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated March 3, 2008:

- "Documentation not supportive of unusually costly or lengthy stay.
- Documentation not supportive of unusually extensive services.
- Correctly reimbursed surgical per diem X 2, with additional payment for documented & pre-authorized implants, provider cost X 110%."

Response Submitted by: Claims Management, Inc.

Respondent's Position Summary Dated March 4, 2008: "This firm has been retained to represent the Carrier in the above-referenced matter...Enclosed please find documents responsive to this issue for your review. I am filing the DWC-60 Form on behalf of the above-referenced insurance carrier in response to the Requestor's dispute for fee reimbursement for the date of service on 08/23/07 through 08/25/07. As a result of the review, no additional payment has been recommended towards the amount in dispute."

Response Submitted by: Hoffman Kelley, Attorneys At Law

SUMMARY OF FINDINGS

| Disputed Dates | Disputed Services | Amount In Dispute | Amount Due |
|---|-----------------------------|-------------------|------------|
| August 23, 2007 through August 25, 2007 | Inpatient Hospital Services | \$44,187.93 | \$0.00 |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1, 31 *Texas Register* 3561, effective May 2, 2006, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- 11 – THE RECOMMENDED ALLOWANCE FOR THE SUPPLY WAS BASED ON THE ATTACHED INVOICE.
- 13 – AN ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED FOR IMPLANTS/PROSTHETICS.
- 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- 169 – REIMBURSEMENT BASED ON RATIO, PERCENTAGE OR FORMULA SET BY STATE GUIDELINES.
- 268 – PLEASE SUBMIT SUPPORTING DOCUMENTATION IDENTIFYING MEDICAL NECESSITY FOR THE PROCEDURE BILLED.
- 275 – THE CHARGE WAS DISALLOWED; AS THE SUBMITTED REPORT DOES NOT SUBSTANTIATE THE SERVICE BEING BILLED.
- 285 – PLEASE REFER TO THE NOTE ABOVE FOR A DETAILED EXPLANATION OF THE REDUCTION.
- 309 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
- B12 – SERVICE NOT DOCUMENTED IN PATIENTS' MEDICAL RECORDS.
- 5036 – COMPLEX BILL – REVIEWED BY MEDICAL COST ANALYSIS TEAM – UR/JE

U.S. Bankruptcy Judge Michael Lynn issued a “STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS,” dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the claim adjudication process as to the workers’ compensation receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 trustee of the debtor’s estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer’s behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.

Issues

1. Did the audited charges exceed \$40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals’ November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 South Western Reporter Third 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that “to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services.” Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals’ November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed \$40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that “Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection...” 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states “...to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold.” Furthermore, (A) (v) of that same section states “...Audited charges are those charges which remain after a bill review by the insurance carrier has been performed...” Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal \$75,097.10. The Division concludes that the total audited charges exceed \$40,000.
2. In its original position statement, the requestor asserts that “This bill should have been audited and reimbursed per the Stop-Loss reimbursement factor and methodology per the criteria as defined in TDI-DWC rule 134.401(c)(6)(A).” 28 Texas Administrative Code §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that “This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission.” The Third Court of Appeals’ November 13, 2008 opinion states that “to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services.” The requestor’s original position statement failed to

discuss the particulars of the admission in dispute that may constitute unusually extensive services. In its supplemental position statement, the requestor considered the Courts' final judgment. In regards to whether the services were unusually extensive, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually extensive services. The requestor's supplemental position statement asserts, that "The services rendered to [Claimant] were unusually costly and extensive...because: [Claimant] underwent multiple surgeries. [Claimant] suffered complications." The requestor's position that this admission is unusually extensive due to surgical procedures and complications fails to meet the requirements of §134.401(c)(2)(C) because the requestor failed to demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgeries or admissions. The division concludes that the requestor failed to meet the requirements of 28 Texas Administrative Code §134.401(c)(2)(C).

3. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor in its supplemental position summary states:

The costs were front-loaded. The cost associated with the hospital's services in this case are front loaded-i.e. the injured employee underwent complicated surgical procedures requiring an investment in skilled professionals and advanced facilities and medical equipment.

The requestor does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for the spinal surgery. Therefore, the requestor fails to demonstrate that the resources used in this particular admission are unusually costly when compared to resources used in other types of surgeries.

The division concludes that the billed charges for the services do not represent the cost of providing those services. The requestor fails to demonstrate that the hospital's resources used in this particular admission are unusually costly.

4. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements*. The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.
 - Review of the submitted documentation finds that the services provided were ICU; therefore the standard per diem amount of \$1,560.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission..." The length of stay was two days. The ICU per diem rate of \$1,560.00 multiplied by the length of stay of two days results in an allowable amount of \$3,120.00.
 - 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)." A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at \$40,477.25. The medical documentation provided finds that although the requestor submitted purchase orders to support what the requestor was charged by the supplier for the implantables, there was no documentation found to support the amounts that the requestor paid for the implantables. The division finds that the cost to the hospital for the implantables billed under revenue code 278 cannot be established; therefore no reimbursement can be recommended for these items.

The division concludes that the total allowable for this admission is \$3,120.00. The respondent paid \$12,134.90. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount*, and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

| | | |
|-----------|--|-----------|
| _____ | _____ | 3/21/2013 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.